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CHAPTER 19

Gender Issues in Counseling

CAROLYN ZERBE ENNS

During the early years of the women's movement, Weisstein (1968/1993) declared that "psychology has nothing to say about what women are really like, what they need and what they want, essentially, because psychology does not know" (p. 197). Weisstein was especially critical of psychology's exclusion and limited view of women's lives as reflected in the fields of personality and psychotherapy. Thirty years later, however, the body of research on women's lives has become so extensive that authors of psychology of women texts must be highly selective in choosing what information to include (Hyde, 1996; Matlin, 1996). During the early 1980s, psychologists also identified the inadequacy of traditional androcentric models for understanding men's lives, noting that traditional masculine gender roles are associated with substantial conflict and stress (e.g., O'Neil, 1981; Pleck, 1981). As a result, profeminist approaches to the psychology and counseling of men have become increasingly visible within psychology (e.g., Andronico, 1996; Kupers, 1993; Levant & Pollack, 1995). In fact, computer (PsycLIT) searches of journal articles for the 1990s yield substantially more titles related to men's gender role conflict and stress than women's experience of these issues.

The purpose of this review is to apply this large body of nonsexist, feminist, and profeminist literature to gender-related counseling issues. The frameworks I have chosen for organizing this review are the Division 17 Principles Concerning the Counseling/Psychotherapy of Women (American Psychological Association, [APA], 1979) and Fitzgerald and Nutt's (1986) elaboration of these principles. The Division 17 Principles represent an especially appropriate foundation for this chapter because they were endorsed unanimously by the Executive Committee of Division 17 in 1978 and were subsequently endorsed by Divisions 12 (clinical psychology), 16 (school psychology), 29 (psychotherapy), and 35 (psychology of women), as well as the APA Education and Training Board. The Division 17 Principles have provided a basis for considering gender-related counseling issues for over 20 years. Yoder's recent (1999) text uses these principles to organize the discussion of feminist practice, further demonstrating the enduring value of this document. Although originally written as a guide for counseling women, these principles have significant implications for working with both men and women. The original document contained 13 specific principles. For this chapter, however, I have organized the principles as they relate to three major categories: knowledge base (Principles 1, 2, and 3), counselor attitudes (Principles 4, 7, 11, and 12), and counseling process and skills (Principles 2, 5, 6, 7, 8, 9, 10, and 13). Because of the explosion of knowledge about gender during recent decades, it is impossible to address adequately the recent counseling literature on gender in a single chapter. Thus, this review is highly selective and incomplete. Given the artificial nature of addressing gender issues in isolation from other aspects of identity, this chapter emphasizes the diversity of men and women whenever possible.

Special thanks to Gail Hackett for creating the outline and organizational framework for this chapter.

COUNSELOR KNOWLEDGE BASE

The Division 17 Principles outline the centrality of the counselor's knowledge base, including the importance of familiarity with the biological, psychological, and social issues that influence women and men; knowledge about subgroups of men and women; and the manner in which life experiences may influence women and men in diverse ways. Much of the knowledge relevant to gender, development, and sexual orientation is summarized by Fassinger (this volume). This chapter builds on her framework by emphasizing counseling implications. Thus, this discussion of knowledge is limited to the articulation of key assumptions and an overview of three major gender-related counseling concerns: (1) interpersonal violence; (2) family, career, and multiple role issues; and (3) body image issues.

Basic Assumptions for Organizing Knowledge about Gender

This chapter is based on the assumption that "gender is what culture makes out of the 'raw material' of biological sex" (Unger & Crawford, 1996, p. 18; see also Fassinger, this volume). Gender behaviors are enacted at an individual level as gender roles, at the interpersonal level as cues that shape reactions and perceptions, and at the social structural level as a system of power relations between and among men and women. The literatures on the biological, psychological, and sociological issues associated with gender are extensive, and the integration of these multiple domains of knowledge supports an effective biopsychosocial approach to gender (Brown, 1994; McGrath, Keita, Strickland, & Russo, 1990).

Since Weisstein (1968/1993) voiced her criticisms some 30 years ago, psychologists have become more cognizant of the limitations of many traditional psychological theories and have made significant advances in adopting more inclusive models of mental health (Brown & Brodsky, 1992; Enns, 1993). It remains important, however, for counseling psychologists to be attentive to subtle biases that remain embedded in theory. Lerman's (1986) criteria for feminist personality theory provide a useful framework for assessing the adequacy of theoretical models that provide a foundation for our knowledge base. Gender-fair models (1) view both women and men positively and centrally; (2) avoid particularistic terminology associated with traditional gender roles (e.g., by using terms such as parenting instead of mothering); (3) encompass the diversity and complexity of women's and men's lives and identities; (4) recognize the inextricable connection between the internal and external worlds of women and men; (5) attend to the manner in which gender, sexual orientation, race, ethnicity, and ability influence internal self-constructions; and (6) support non-sexist and feminist approaches to counseling and psychotherapy (Lerman, 1986).

Discussions about gender within psychology have often been dominated by controversies regarding gender difference and similarity. Some popular research programs were built on an idealistic and "uncomplicated vision" (Eagly, 1995, p. 149) that methodologically sound studies would quickly dispel mythologies about sex and gender by revealing gender similarities. Other frameworks (e.g., Gilligan, 1982; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) have emphasized differences between men and women and have redefined previously undervalued or unacknowledged aspects of women's traditional experience as unique women's strengths. Hare-Mustin and Marecek (1988) identified the first approach to theory and research as contributing to beta bias, or the minimization of the impact of gender on women's and men's lives, and the second framework as contributing to alpha bias, or the exaggeration of difference between men and women. Both approaches to gender may prompt individuals to see gender as lodged within the person rather than as actively created within relationships and social structures; they may perpetuate the notion that "the categories of 'man' and 'woman' are natural, self-evident" and unitary (Marecek, 1995, p. 162). Both approaches may compel individuals to draw conclusions about "generic" men and women in isolation from other

important aspects of social position and identity, such as race, culture, ethnicity, sexual orientation, and social class.

As noted by Morawski (1987), it is impossible for men and women to "operate (effortlessly) in a social vacuum where expectations for gender-related behavior . . . are noticeably absent" (p. 55). Gender involves "doing" or engaging in behavior (West & Zimmerman, 1987), and is "materialized" in social encounters (Deaux & LaFrance, 1998). Models and foundations of knowledge that focus on "how" gender is constructed and that attend to the diversity of human experience support an integrated biopsychosocial approach to counseling. Gender schema theory (Bem, 1993) and interactive models of gender (Deaux & Major, 1987) are consistent with these assumptions in that they conceptualize gender and gender-related attitudes as embedded in a complex set of cognitive beliefs that are shaped by social interactions and power structures.

Knowledge of Gender-Related Concerns

Whereas women are more likely to exhibit higher rates of many disorders such as depression, eating disorders, dissociative identity disorder, posttraumatic stress disorder, and many of the anxiety disorders (e.g., agoraphobia, specific and social phobias), men are more likely to experience many of the addictive disorders and antisocial behaviors (Nolen-Hoeksema, 1998). Most of these disorders are associated with a complex array of factors, including biology, cognitive styles, economic factors, and culture (see Yoder, 1999, for an extended discussion of these factors). A gender analysis of such psychological problems also suggests that these problems often reflect men's and women's efforts to escape gender-role prescriptions, contend with the double binds and contradictory demands related to gender roles, or subscribe more closely to gender role stereotypes than do typical men or women (Franks & Rothblum, 1983; Kaplan, 1983). Gaining knowledge about the specific types of gender role conflicts that men and women face as well as the manner in which these role issues are shaped by race, ethnicity, and sexual orientation is useful for (1) understanding the symbolic communication and coping function of symptoms; (2) differentiating between and conceptualizing the personal, interpersonal, and cultural/social components of distress; and (3) addressing these issues in an empathic and comprehensive framework. Methods for dealing with gender role issues and conflict are addressed more completely in the section on counseling process and skills. The following discussion of interpersonal violence, multiple role, and body image issues illustrates the type of knowledge that facilitates effective counseling regarding many gender-related issues.

Interpersonal Violence

The prevalence of interpersonal violence, especially violence against women, is extensive, and interpersonal violence of many kinds is related to psychological distress (Goodman, Koss, & Russo, 1993). Studies consistently find high levels of physical or sexual abuse histories in studies of psychiatric samples (e.g., Bryer, Nelson, Miller, & Krol, 1987; A. Jacobson, 1989). Carmen, Rieker, and Mills (1984) found that 43% of 188 psychiatric patients had histories of physical and/or sexual abuse, and 53% of female patients and 23% of male patients had experienced physical or sexual abuse. Koss (1993) concluded that between 40% and 60% of patients seeking psychiatric care have experienced physical or sexual abuse of some type.

Rape prevalence rates for women ranging from 14% to 25% have been reported in eight major studies (Koss, 1993). Acute posttraumatic stress disorder (PTSD) is experienced by up to 95% of rape survivors within two weeks following rape, and about 50% continue to meet the diagnostic criteria of PTSD three months after rape (Foa & Riggs, 1995; Nolen-Hoeksema, 1998). Studies also find that between one-fourth (Straus & Gelles, 1990) and one-half (Stark & Flitcraft, 1988) of women in marital or other intimate relationships are the victims of domestic violence, and

roughly half of battered women meet the diagnostic criteria for PTSD (Saunders, 1994). These trauma symptoms often co-occur with a wide range of other psychological problems.

Most studies of domestic violence have focused primarily on heterosexual relationships, but it is also important for counselors to acknowledge the extent and seriousness of domestic violence in lesbian (Browning, Reynolds, & Dworkin, 1991; Renzetti, 1992) and gay male (Island & Letellier, 1991) relationships. Although the rates of domestic violence and consequences of battering appear to be similar in heterosexual and homosexual relationships, the social and relationship dynamics associated with battering may be unique (Renzetti, 1992). Renzetti's study of battering in lesbian relationships noted that the major correlates of abuse included issues of autonomy and dependency, jealousy, power imbalances, and substance abuse. Battered individuals in same-sex relationships often face additional obstacles because of the heterosexist assumptions that may underlie beliefs about violence (Letellier, 1994) and homophobic attitudes on the part of mental health service providers, shelter personnel, and legal personnel (Letellier, 1994; Renzetti, 1992).

The psychological impact of child physical and sexual abuse has received sustained attention during the past decade. A frequently cited national survey found that 27% of women and 16% of men disclosed a history of child sexual abuse (Finkelhor, Hotaling, Lewis, & Smith, 1990). One survey found that compared with individuals without a victimization history, male and female victims of sexual abuse were two times more likely to meet the criteria of a psychiatric disorder sometime during their lifetime (Stein, Golding, Siegal, Burnham, & Sorenson, 1988). Browne and Finkelhor's (1986) review concluded that approximately 40% of sexual abuse survivors experience a level of distress that may require psychotherapy. The sequelae of sexual abuse are diverse and include depression, PTSD, dissociation, sexual dysfunction, self-esteem problems, and eating disorders (Pruitt & Kappius, 1992; Roesler & McKenzie, 1994). A recent study found that approximately 50% of women who experienced adult abuse also reported a history of child abuse. The impact of interpersonal violence may be cumulative, as revealed by the finding that women who experienced abuse both as children and adults exhibited more physical symptoms and higher levels of psychological distress than did those who experienced abuse during a single stage of life (McCauley et al., 1997).

Although a history of abuse or interpersonal violence is related to psychological distress, the level of psychological distress is variable, depending on the nature of the sample, developmental factors, family climate factors, and the range and pervasiveness of traumatic events (Rind, Tromovitch, & Bauserman, 1998). For example, a meta-analysis of 59 studies of college samples (Rind et al., 1998) found that students with a history of child sexual abuse were "slightly less well adjusted" (p. 22) than those persons without such a history. Furthermore, family environment factors explained more of this lower level of adjustment than did sexual abuse. The meta-analysis also revealed that college men and women may have different feelings and perceptions about their personal sexual abuse, with female victims reporting more negative experiences and reactions than male victims. These findings point to the importance of studying patterns of resilience, as well as pathology, that are displayed by victims of abuse.

Although substantial data attest to the extensive negative consequences of intimate violence, therapists sometimes underplay the seriousness of such violence or do not address the violence (Harway & Hansen, 1993). As a foundation for working with interpersonal violence, it is important for counselors to be knowledgeable about violence statistics, research findings regarding the dynamics and types of interpersonal violence (including variations by sexual orientation, race, and culture), the diverse and variable psychological consequences of violence, and methods for assessing violence and trauma. Given the multidimensionality of violence, it is also important for interventions to attend to a range of influences, including intrapsychic factors, developmental factors, family influences, power dynamics, and the social context in which violence occurs. Familiarity with crisis intervention procedures, methods for addressing posttraumatic symptoms and

reactions, the costs and benefits of conjoint therapy for couples dealing with recent abuse, and methods for working with perpetrators are also valuable assets (American Psychological Association, 1996; Gauthier & Levendosky, 1996; Harway & Evans, 1996; Koss et al., 1994; Philpot, Brooks, Lusteran, & Nutt, 1997; Tolman, Mowry, Jones, & Brekke, 1986; Walker, 1994).

Although women are more likely to experience significant psychological and physical harm as a consequence of adult interpersonal violence in heterosexual relationships, adult women and men report engaging in similar amounts of physical and verbal aggression. Compared with men, however, it appears that women are more likely to report their own negative behaviors, use aggression for different reasons (e.g., self-defense versus sexual jealousy), use psychological or indirect aggression, and limit their aggression to domestic spheres (Koss et al., 1994; J.W. White & Kowalski, 1994). Men are more likely than women to perpetrate multiple, more severe, and more aggressive actions (Koss et al., 1994). The most significant risk factor associated with becoming a victim of violence in the home is being female (American Psychological Association, 1996). It should be noted, however, that there are also significant differences within groups of men and women with regard to motivation for and levels of violence. For example, N.S. Jacobson and Gottman (1998) found two distinctive patterns among men who used severe violence. The first pattern, which is marked by physiological arousal during violent episodes, was more characteristic of batterers who showed emotional attachment to their partners and who appeared to use violence to prevent abandonment. The second pattern, which is not associated with physiological arousal, was more frequently displayed by men who showed low levels of emotional attachment to partners and used violence as a form of control or an assertion of independence.

The findings described in this section point to the diversity of violence and the complexity of intervening effectively with individuals who experience and display violence. Working with violence issues is a challenge within a climate that is currently characterized by a general "backlash" against feminism and feminist research on the treatment of violence (Enns, 1996). Victims of violence have sometimes been described as suffering from "rape hype" (Roiphe, 1993) or "false memory" (False Memory Syndrome Foundation, 1992), and researchers have been accused of exaggerating claims about the prevalence of violence or the gendered nature of much interpersonal violence. Within this climate, a social constructionist perspective is helpful for examining the strengths and survival skills of victims, the manner in which and the reasons why women and men exhibit aggression, and the ways in which power is related to aggressive and abusive interpersonal acts.

Family, Career, and Multiple Role Issues

Counseling psychologists have made significant contributions to feminist perspectives in career psychology (e.g., L. Brooks & Forrest, 1994; Hackett & Lonborg, 1994), furthering knowledge of the specific career concerns of men and women, the balancing of career and personal roles, conflicts and discrepancies between these roles, and the diverse ways in which these roles are enacted. Gilbert's (1992) chapter on gender in the second edition of this *Handbook* and Fassinger's chapter (this volume) provide excellent overviews of many gender-related career and family concerns.

In general, a combination of work and family roles is normative during adulthood, and the combination of these roles is generally more satisfying than traditional alternatives (Barnett & Rivers, 1996). Although women have steadily increased their involvement in careers and men have increasingly acknowledged the psychological costs and gender role conflicts of a life that centers primarily on achievement and work (e.g., Kupers, 1993; Levant & Pollack, 1995), significant issues and inequities between men and women remain. Employed women earn 76% as much as men (compared with 63% in 1979); are more likely to experience poverty or to remain concentrated in lower-status jobs in clerical, service, and sales domains (Herz & Wootton, 1996); and

assume substantially more household and family responsibilities than men (Steil, 1994). The consideration of these issues is crucial for helping individuals and partners create mutually acceptable agreements about work and personal lives.

Family and work arrangements are diverse, and many traditional models are inadequate for conceptualizing the gender-related concerns of partners and their families (Demo & Allen, 1996; Laird & Green, 1996). The psychological literature contains a paucity of information regarding feminist perspectives on fathering (Silverstein, 1996). Most research programs have tended to view the mother-child dyad as the primary context in which development occurs. As a result, research about positive fathering is underrepresented, and the assumption that the mother-child bond is central, exclusive, unique, and the most important factor for healthy child development is perpetuated (Silverstein & Phares, 1996). A second problem is that heterosexist assumptions underlie many dominant theories of family life (Demo & Allen, 1996). Although researchers have gathered a substantial body of knowledge about the dynamics and issues of lesbian and gay families, this material is rarely integrated with mainstream studies of the family (C.A. Parks, 1998). Recent research indicates, for example, that despite the difficult legal, fiscal, and societal barriers, lesbian couples establish well-functioning families that nurture socially tolerant and well-adjusted children (C.A. Parks, 1998; Patterson & Redding, 1996). Knowledge of this literature is helpful for challenging negative stereotypes and prejudices about, and ensuring equitable treatment of, lesbian and gay male families (see Fassinger, this volume, for further discussion).

Body Image, Objectification, and Mental Health

Gilbert's (1992) review of gender concluded that cultural beliefs and stereotypes about beauty contribute to many gender-related problems. An early content analysis of women's portrayal in the media (Courtney & Lockeretz, 1971) identified the following themes: women as homebound, women as dependent, women as engaging in unimportant activity, and women as sex objects. Recent content analyses (e.g., Plous & Neptune, 1997) have found that women are less likely to be depicted as homebound and more likely to be portrayed in work roles; however, they are also depicted more frequently as sex and decorative objects. This "objectification" of women in the media and throughout other cultural institutions may contribute to mental health risks marked by body image dissatisfaction and self-objectification.

Research reveals that disordered eating and body dissatisfaction are associated with exposure to body ideals presented in the media (e.g., Stice & Shaw, 1994). Objectification theory (Fredrickson & Roberts, 1997; Noll & Fredrickson, 1998) proposes that women learn to assume an observer's point of view and apply internalized cultural stereotypes of beauty when they view and evaluate their own bodies. This internalization of the culture may lead to habitual body monitoring or surveillance, which contributes to women's shame and anxiety, the reduction of peak motivational states or "flow," and decreased awareness of internal signals of hunger and satiation. Self-objectification may also place individuals at increased risk for a wide range of disorders such as anxiety states, depression, disordered eating, and sexual dysfunction. Several studies have found that self-objectification predicts shame and restrained eating in women (Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998; McKinley & Hyde, 1996; Noll & Fredrickson, 1998). Compared with men, women were also found to engage in greater self-objectification and to perform worse on a math test after being exposed to a condition designed to elicit body self-objectification (trying on a swimsuit) (Fredrickson et al., 1998).

Issues related to body satisfaction, body image, and eating may be experienced in unique ways by heterosexual women, lesbian women (Beren, Hayden, Wilfley, & Grilo, 1996; Beren, Hayden, Wilfley, & Striegel-Moore, 1997), and women of color (Harris, 1995; Joiner & Kashubeck, 1996). Furthermore, although eating disorders and body dissatisfaction affect women disproportionately, recent studies also reveal body dissatisfaction and eating disturbances within subgroups of men, such as gay men (Beren et al., 1996; Siever, 1994).

Of particular interest have been recent findings that lesbians express less dissatisfaction about their bodies than heterosexual women (Bergeron & Senn, 1998; Herzog, Newman, Yeh, & Warshaw, 1992; Siever, 1994). Gettelman and Thompson (1993) found that compared with lesbians, heterosexual women were more appearance oriented, disclosed more problematic eating behaviors, and showed more concern about body image, weight, and dieting. Another study found that lesbians chose a heavier ideal weight, were less concerned about their current weight, and did not diet as frequently as heterosexual women (Herzog et al., 1992). Although there is substantial overlap between lesbian and heterosexual women's body image attitudes—for example, members of both groups feel overweight and concerned about appearance (Beren et al., 1997)—lesbian women may internalize oppressive societal norms about the body to a lesser degree and may be more adept at resisting these attitudes (Bergeron & Senn, 1998).

When both men and women were included in a study of body satisfaction, heterosexual women and gay men disclosed the highest levels of dissatisfaction with their bodies (Siever, 1994). Heterosexual men showed the least concern about their own bodies, but the most concern about the bodies of their partners. Some of the most adverse effects of body objectification for heterosexual men may be revealed in their susceptibility toward objectified images of women that permeate the culture. N.J. MacKay and Covell (1997) found that compared with men who viewed a “progressive” advertisement, men exposed to a sex image advertisement showed lower acceptance of feminism and more attitudes supportive of sexual aggression. In another study, men exposed to sexually objectifying advertisements chose more sexist questions for a female job candidate, and were rated as acting in more sexualized and inappropriate ways than were men exposed to non-objectifying advertisements (Rudman & Borgida, 1995).

As with other issues presented in this section, it is important for counselors to be attentive to the diversity of clients and to be knowledgeable about individual, psychological, and sociocultural factors that influence body satisfaction, dissatisfaction, and self-objectification.

COUNSELOR ATTITUDES

According to Principles 4, 7, 11, and 12 of the Division 17 Principles, self-knowledge is central to competent work with gender-related concerns. These principles suggest that counselors make efforts to understand the variety of oppressions that influence clients and examine their own personal attitudes to ensure that their practices support optimal counseling goals and outcomes (American Psychological Association, 1979). They also suggest that self-care activities support competent practice. The first major category in this section discusses counselor attitudes as they relate to sexism and gender bias, antigay bias and heterosexism, personal privilege associated with race, and the interactive effects of sexism, racism, classism, and heterosexism. The second major category discusses the relevance of self-care to the maintenance of positive counselor attitudes.

Self-Examination of Values and Biases

Sexism and Gender Bias

The literature on racism and sexism indicates that blatant forms of sexism and negative attitudes toward women have decreased substantially during recent decades (Campbell, Schellenberg, & Senn, 1997). Researchers have found, however, that contemporary sexism often assumes more subtle and clandestine forms, which have been labeled as (1) modern sexism (Swim, Aiken, Hall, & Hunter, 1995; Swim & Cohen, 1997); (2) neosexism (Campbell et al., 1997; Tougas, Brown, Beaton, & Joly, 1995); and (3) ambivalent sexism (Glick & Fiske, 1996, 1997). Many modern or current forms of sexism/bias are not marked by the open endorsement of inequality, and often go unnoticed because they are embedded within cultural and societal norms. It may be marked by

attitudes such as discrimination is no longer an issue, women and minorities are asking for too much, and many of the gains made by women and minorities are not deserved (Tougas et al., 1995).

Tougas et al. (1995) described neosexism as a "manifestation of conflict between egalitarian values and residual negative feelings toward women" (p. 843), noting that this form of sexism may be associated with unintentional biases or opposition to social policies designed to benefit women or minorities (see also Dovidio & Gaertner, 1996). Swim et al. (1995) also found that individuals scoring high in modern sexism tended to endorse more individualistic values, and to overestimate the percentage of women in male-dominated jobs (e.g., airline pilots, physicians). Both ambivalent sexism and ambivalent racism may be associated with conflicts between the principle of egalitarianism, which leads people to embrace equality and express empathy for "underdogs," and individualism or a Protestant work ethic, which imply that people are responsible for their own fate. Thus, the person who holds subtle racist or sexist beliefs may praise minority group members and women who transcend many of the effects of racism or sexism and become high achievers, but harbor negative attitudes toward more ordinary individuals (Glick & Fiske, 1996).

It is possible that recent "kinder and gentler justifications of male dominance and prescribed gender roles" (Glick & Fiske, 1997, p. 121) may be no less virulent than some blatant biases. Given the subtle nature of contemporary sexism and racism, it may be more difficult for individual men and women who are targets of racist or sexist beliefs to recognize the presence of bias. Thus, some clients may be more likely to internalize subtly sexist or racist attitudes and have greater difficulty resisting the effects of bias. Furthermore, counselors are not immune from internalizing these biases, especially if they are subtle, unintentional, or nonconscious.

Heterosexism, Homophobia, and Antigay Bias

Negative attitudes toward lesbian, gay, bisexual, and transgendered (LGBT) people exist at both blatant and subtle levels. Antigay violence (Fassinger, 1991) reveals that blatant prejudice against LGBT persons is often tolerated and supported within the larger culture. Both blatant prejudice and subtle heterosexist values can have a negative impact on the self-esteem and well-being of gay clients (Phillips & Fischer, 1998). Rudolph (1988) concluded that counselors often hold contradictory attitudes toward homosexuality, often believing concurrently in "the psychological health and potential pathology of homosexuality" (p. 167). Counselors may simultaneously see LGBT clients as fully functioning yet "hampered in their performance in certain positions by the very fact of their sexual orientation" (p. 167).

Several analogue studies, which have conceptualized the subtle heterosexist or homophobic responses that counselors harbor as countertransference reactions, suggest that counselor attitudes toward LGBT people may not be as conflicted as some clinical literature suggests (Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993). Hayes and Gelso found that male counselors did not appear to experience discomfort in reaction to a male client's sexual orientation *per se*, but did experience greater anxiety with HIV-positive than HIV-negative clients. Gelso et al. found that counselors did not show more countertransference reactions to a lesbian client than a heterosexual client. Compared with male counselors, however, female counselors showed greater difficulty recalling a lesbian client's problems. Male and female counselors showed similar levels of recall with a heterosexual client. Authors of both studies found that although participants revealed low levels of homophobia in general, higher levels of homophobia were associated with counselor avoidance of client's feelings and concerns. These studies point to the complexity of homophobia and the likelihood that when counselors hold stereotypes and fears about LGBT clients, they may avoid addressing or responding to important clinical issues.

Heterosexism is often marked by the lack of acknowledgment of the realities and experiences of LGBT clients, which renders their experiences invisible (Fassinger, 1991; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). This practice leads to omission bias, or the omission of circumstances and experiences that are relevant to a group of people (Chernin, Holden, & Chandler,

1997; Garnets et al., 1991). Heterosexuality is often assumed to be a "given"; the lives of LGBT individuals are then judged according to the "normative" experience of heterosexual people. A second problem is connotation bias, which involves using phrases with negative connotations when referring to a minority group (Chernin et al., 1997). For example, Morton (1998) noted that lesbian relationships are often characterized as fused or enmeshed when compared with heterosexual relationship norms. More appropriate and positive phrases for conceptualizing this dynamic include an "ability for empathic relating" or "self-boundary flexibility."

Personal Privilege and Racism

Counselors are not likely to be aware of subtle ethnocentric or androcentric beliefs unless they carefully examine their own experiences of privilege and become educated about the lives and histories of diverse people. McIntosh (1989) described White privilege as the "invisible package of unearned assets which I can count on cashing in each day, but about which I was 'meant' to remain oblivious" (p. 10). These unearned privileges resemble a "weightless knapsack" of "blank checks" that are accorded to people who have greater social and economic power. White privilege includes being able to count on skin color adding to rather than detracting from perceptions of personal reliability, being assured that educational materials will give ample attention to one's race, and being able to accept a job with an affirmative action employer without individuals being suspicious that the job was awarded on the basis of race versus competence.

Espin (1995) cautioned that even when White psychologists have good intentions, they often remain blinded by their privileges. Members of minority cultures generally learn a wealth of information about majority cultures to survive and cope in them, but as a consequence of their privileged status, members of the majority culture often remain ignorant about important aspects of nondominant cultures. Antiracism training, consciousness-raising activities, and efforts to educate oneself about nondominant cultures facilitate ongoing self-examination and conscious acknowledgment of subtle biases (Brown, 1993).

Intersections of Sexism, Racism, Classism, and Heterosexism

Feminist psychologists have been attentive to androcentric biases in psychological theory but have often been blind to their own ethnocentrism. Too frequently, the experiences of White women are seen as synonymous with the experiences of "women in general," or as the normative group to which all other groups of women are compared (Yoder & Kahn, 1993). Psychological research has also tended to focus on negative or dysfunctional behaviors of people of color rather than positive aspects of coping (Wyche, 1993). Furthermore, the behaviors of people of color are sometimes defined as "dysfunctional" because they are judged by the standards of middle-class, White society rather than alternative paradigms that have more relevance for people of color (Espin, 1995).

For many people of color, racism may be a far more visible, virulent, and frequent experience than sexism or heterosexism (Comas-Diaz & Greene, 1994; Kanuha, 1990). If the counselor believes, for example, that women of color have more in common with other women than men who experience a shared oppression, the counselor may deny the relevance of important bonds and sources of support that ethnic minority women form with men who experience racism and other forms of common oppression (Greene & Sanchez-Hucles, 1997). It is also important for counselors to be aware that people of color often experience sexism and heterosexism within their ethnic communities, which further limits their choices and adds to psychological stress (Comas-Diaz & Greene, 1994; Kanuha, 1990). Although gender oppression is one of the common experiences that women face, it is shaped by individual economic, social, historical, and ecological realities (Greene & Sanchez-Hucles, 1997).

Reid (1993) noted that middle-class biases also permeate current psychological theory and that "feminist psychology does not differ greatly in this respect from traditional psychology. Indeed,

poor women are virtually unnamed in feminist work" (p. 134). They are "shut out" and silenced. Reid suggested that feminist psychologists have often held the simplistic and egocentric view that although poor women may experience more racism and sexism than others, this oppression is similar to that experienced by middle-class women.

Kanuha (1990) stated that "if racism functions to oppress non-White people, it interacts with sexism to deny the mere existence of lesbians of color" (p. 173). She suggested that lesbians of color have been virtually invisible, in part because of the subtle racism in White feminist scholarship, which has tended to identify heterosexism as the primary form of oppression that all gay people face. The assumption that all lesbians and gay men suffer equally from homophobia detracts from an understanding of how classism, ageism, and racism contribute to the complexity of gender-related concerns such as domestic violence. Leslie and MacNeill (1995) added that gay people of color must often contend with racism in the gay community as well as homophobia within communities of color. They must achieve a healthy identity in the midst of a minority community which is likely to be homophobic and a majority culture that is homophobic, sexist, and racist.

When gender, race, class, and sexual orientation aspects of identity are conceptualized as "additive" or factors that can be neatly separated from each other, people of diversity may feel forced to choose between or prioritize identities associated with gender, sexual orientation, race, and class. When this occurs, the unique and complex identities of individuals may be written out of existence. It is especially important for White middle-class psychologists to avoid "White solipsism," or the tendency to "think, imagine, and speak as if whiteness described the world" (Rich, 1979, p. 299); and to educate themselves about the myriad interactions of identities, "isms," and contexts that shape the lives of clients (Reid, 1993).

Personal Functioning and Self-Care

Coster and Schwebel's (1997) survey revealed that psychologists rated the following seven items as most central to well-functioning: self-awareness and self-monitoring, a personal value system, balance between personal and professional lives, relationships with family members and partners, vacations, relationships with friends, and personal therapy. Mahoney's (1997) survey found that emotional exhaustion/fatigue was the most frequently cited personal problem encountered by doctoral psychotherapists (43%), and roughly one-third of respondents reported anxiety or depression during the past year. Pope and Tabachnick's (1994) survey of therapists noted that 61% reported having experienced depression, and 29% had felt suicidal at some point. Eighty-eight percent of Mahoney's (1997) sample and 84% of Pope and Tabachnick's sample had participated in personal therapy at some point. The results of these recent surveys point to the importance of self-care for supporting competent professional practice. The next section focuses on two specific issues associated with self-care: vicarious traumatization and issues associated with overidentification or underidentification with clients.

Vicarious Traumatization

Counseling psychologists who have heavy caseloads of survivors of various forms of abuse and violence may be especially vulnerable to physical and emotional exhaustion, role strain, and vicarious traumatization (Pearlman & Saakvitne, 1995). Schauben and Frazier's (1995) study of female counselors who work with sexual violence revealed that compared with counselors who saw fewer victims of violence, those who worked with a higher percentage of survivors reported more PTSD symptoms, more disrupted cognitions about themselves and others, and more signs of vicarious traumatization. However, the same counselors did not experience higher levels of negative emotion such as depression or hostility, nor did they exhibit significant signs of burnout. Pearlman and MacIain's (1995) exploratory study found that therapists (136 women and 52 men) who were new to trauma work reported higher levels of distress and greater disruptions of basic schemas than

seasoned professionals. Compared with those with no personal trauma history, therapists with a trauma history also reported more disruptions of basic schemas (e.g., safety, self-trust, self-esteem) and higher levels of distress. In general, those therapists with the highest levels of distress were not receiving supervision and had engaged in trauma work for less time.

Participants' responses to open-ended questions (Schauben & Frazier, 1995) reveal additional information about aspects of working with violence survivors that are especially difficult, including: (1) the difficulty of hearing stories of abuse and experiencing clients' pain; (2) the challenge of establishing trust with clients who have been victimized; and (3) the frustrations of working with other systems, such as legal and mental health systems, that often provide inadequate assistance to survivors. Although limited empirical data about vicarious traumatization exist, the results of these studies point to the value of self-care, professional training for working with violence, and supervision.

Overidentification or Underidentification with Clients

Providing psychotherapy to survivors of violence or clients who share similar life histories with the counselor may pose special challenges. Surveys of mental health practitioners reveal that roughly one-third report having experienced sexual or physical abuse as a child or adolescent (Little & Hamby, 1996; Polusny & Follette, 1996; Pope & Feldman-Summers, 1992). Pope and Feldman-Summers indicated that when the entire life span was considered, roughly two-thirds of female therapists and one-third of male therapists reported at least one form of physical or sexual abuse. Elliott and Guy (1993) found that women therapists reported higher levels of sexual abuse (43%) than did women in other professions, and Nuttall and Jackson's (1994) survey found that 21% of clinicians reported a history of child sexual or physical abuse. In general, female therapists report substantially higher levels of past abuse than do male therapists.

Although these abuse experiences have the potential to influence the emotional competence of therapists (Pope & Vasquez, 1998), studies have found no differences between traumatized and nontraumatized therapists with regard to their perceptions about how abuse issues should be treated (Badura & Stone, 1998), their perceived competence for working with abuse (Pope & Feldman-Summers, 1992), and the therapeutic practices (Polusny & Follette, 1996) and assessment practices and diagnostic formulations (Little & Hamby, 1996) they reported using. However, therapists with abuse histories reported having more concerns about countertransference, such as making boundary mistakes or crying with clients, and disclosed using more coping strategies to enhance or support their practice as psychotherapists (Little & Hamby, 1996). Compared with those with no trauma history, respondents with an abuse or trauma history also reported higher rates of personal trauma symptoms (Follette, Polusny, & Milbeck, 1994; Pearlman & MacIan, 1995), and greater reluctance to participate in long-term marital/intimate relationships (Nuttall & Jackson, 1994). Survey findings suggest that therapist abuse status is not related to therapists' practices and competence, and that therapists' child abuse experiences do not appear to affect the quality of treatment that clients receive. However, findings also suggest that compared with nonabused therapists, therapists with abuse histories may experience somewhat more challenging issues regarding emotional identification and boundaries.

Several studies suggest that psychotherapists with an abuse history are somewhat more likely to believe clients who disclose abuse (Nuttall & Jackson, 1994) or to believe that their memories of abuse are accurate (Polusny & Follette, 1996). Counselors with similar experiences to those of their clients may have a deeper understanding of clients' concerns, and may develop a deep empathy that facilitates growth and change. On the other hand, they may be vulnerable to restimulation of their own pain. If this occurs, counselors can lose objectivity or overgeneralize the relevance of their personal experience for understanding their clients' concerns. When counselors have personal histories similar to those of clients, self-care activities, consultation, and supervision may be especially beneficial (Pearlman & Saakvitne, 1995).

Therapist gender may also be related to issues of identification with clients. Jackson and Nuttall (1993) found that male mental health professionals were less likely than female mental health professionals to believe allegations of sexual abuse. Badura and Stone (1998) found that compared with females, male psychologists were less likely to predict positive prognoses for clients who had recently remembered abuse (there were no gender differences for always remembered abuse). Adams and Betz (1993) noted that male clinicians were less optimistic about a client's likelihood of overcoming problems associated with incest and defined incest more narrowly than did female clinicians. Little and Hamby (1996) found that female therapists were more likely than male therapists to report screening for abuse during assessment, to see the effects of abuse as long term and harmful, to believe that counseling survivors of abuse is difficult, and to use coping mechanisms to deal with the complexities of their work. With regard to countertransference concerns, female therapists were somewhat more likely than male therapists to report feeling strong emotions such as hopelessness, disgust, and anger; crying with clients; and making boundary mistakes in therapy. In contrast, male therapists were somewhat more likely to report being sexually turned on or placing some blame on the client (Little & Hamby, 1996). In general, these findings suggest that sexual abuse issues may be related to somewhat different emotional reactions on the part of male and female clinicians, and that female clinicians are more likely than male clinicians to identify sexual abuse issues as salient. Sexual abuse and other forms of interpersonal victimization are experienced more frequently by women than men (see previous section on interpersonal violence), and this gender-related reality may be related to male and female therapists' perceptions and emotional reactions.

In general, findings relevant to counselor gender or abuse status alone are associated with relatively modest or small effect sizes. Therapists' perceptions and practices appear to be related to a complex array of other factors, including the therapist's theoretical orientation and gender role attitudes and ideology (Adams & Betz, 1993; Little & Hamby, 1996). Results of studies suggest that it is desirable for all clinicians to receive education and training about the potential for overidentifying and underidentifying with clients.

COUNSELING PROCESS AND SKILLS

In the following sections, I address counseling skills for working with gender issues as they relate to the therapeutic relationship, assessment, theoretical approaches to intervention, facilitative therapeutic procedures, and social change (Principles 2, 5, 7, 8, 9, 10, and 13).

The Therapeutic Relationship

Gender-Related Process Issues

Issues of power permeate all human relationships, including psychotherapy relationships (Pope & Vasquez, 1998). Many clients have experienced a range of oppressive experiences, victimization, and abuses of power in their personal lives, and may be especially sensitive to the use of power or may have difficulty recognizing how power can be used effectively. Because of the differential levels of power that men and women have historically held, counselor modeling of the appropriate use of power may be especially important when counseling focuses on gender-related concerns. The principles therefore suggest that it is therapeutic for the counselor to form relationships with clients that model collaborative interaction (Hill & Ballou, 1998; Wyche & Rice, 1997).

The positive and respectful negotiation of power is facilitated through informed consent and the negotiation of counseling contracts or rights and responsibilities statements that outline the nature and goals of therapy, the counselor's theoretical orientation, the costs and benefits of counseling, expectations of client and counselor, and alternatives to counseling (Pope & Vasquez,

1998). These procedures demystify psychotherapy, demonstrate respect for clients' autonomy, and convey confidence about clients' ability to make judgments that are in their best interest (Hill & Ballou, 1998; Wyche & Rice, 1997).

Power differentials are also reflected in language and nonverbal behavior. The Division 17 Principles (American Psychological Association, 1979) highlight the importance of using non-sexist language. Research clearly demonstrates that when people use masculine nouns and pronouns as "generic" language, responses are "predominantly—and usually overwhelmingly—male" (Henley, 1989, p. 65). Use of masculine generics also has been shown to result in women's lower comprehension or recall of material (Crawford & English, 1984), and women's belief that material is less personally relevant (D.G. MacKay, 1980). An equally important but subtle use of biased language is reflected in the structure of language that is used to compare men and women on many psychological variables. Tavris (1993a) noted that the pervasiveness of "male as normative" standards are revealed in a sentence that reads "women are less self-confident than men" instead of "men are not as realistic as women in assessing their abilities." When language does not refer inclusively to activities and roles related to intimate partnerships and parents, heterosexist biases are also conveyed (Committee on Lesbian and Gay Concerns, 1991). Counselors must maintain awareness that language is central to conveying standards of normalcy within psychology and seek to avoid comparisons that reinforce existing power differentials.

One of the few well-established gender differences is women's greater sensitivity to nonverbal cues and greater accuracy in decoding nonverbal language (Hall & Halberstadt, 1997; LaFrance & Henley, 1997). In addition, psychological research reveals that men and women use nonverbal language in different ways. On average, men interrupt women more frequently than women interrupt men, men are more likely to talk more than women in mixed groups, men are more likely to use silence to control discussion, men are more likely to touch women than women to touch men, women smile more than men, and men use greater personal space than women (see Gilbert & Scher, 1999 for a review). Some authors indicate that gender differences in nonverbal behaviors, such as posture, personal space, touching, eye-contact, facial expression, speaking styles, and decoding skill, are consistent with an "oppression hypothesis" (e.g., LaFrance & Henley, 1997; Unger & Crawford, 1996). In other words, people with higher status use nonverbal skills to emphasize and demarcate power. Conversely, individuals with lower levels of power enhance their coping and survival by being able to discern the desires and intentions of those with greater power. The debate about why gender differences in nonverbal behavior exist is not yet resolved (Hall & Halberstadt, 1997; LaFrance & Henley, 1997). However, it is important for counselors to be aware that nonverbal expression can be used to emphasize one's position as a more powerful or subordinate person, and to make efforts to use nonverbal communication that supports egalitarian relationships.

Boundary Issues

Boundary violations and power imbalances assume many forms, ranging from blatant forms of sexual misconduct to less invasive but problematic behaviors such as using touch or self-disclosure inappropriately. This section focuses on boundary management as it relates to self-disclosure, touch, and sexual misconduct. Fitzgerald and Nutt (1986) indicated that self-disclosure is an important outgrowth of self-examination and self-awareness and is useful for creating "mutually responsible" (p. 206) relationships. Self-disclosure in counseling has been a popular area of research (Watkins, 1990), and studies consistently find that analytically or traditionally oriented therapists are less likely to use self-disclosure than are other counselors (e.g., Edwards & Murdock, 1994; Simi & Mahalik, 1997). Feminist therapists, who see the discussion of gender issues as central to achieving counseling goals, may view self-disclosure in distinctive ways. They tend to use self-disclosure to equalize the psychotherapy relationship, empower the client, and establish informed consent. Simi and Mahalik (1997) found that compared with other therapists, feminist therapists expressed greater willingness to share information about personal background, and were more

likely to be open to client requests for self-disclosure. Compared with psychoanalytic/dynamic therapists, feminist therapists were more likely to believe that self-disclosure decreases power differentials, is useful for validating clients' feelings, and can be liberating or empowering for clients.

A recent qualitative study revealed that clients often described themselves as discussing important personal issues immediately preceding counselor self-disclosure (Knox, Hess, Petersen, & Hill, 1997). Counselor disclosures were typically about past (not immediate) personal experiences, and clients generally believed that therapists disclosed in order to normalize their experiences or to provide reassurance. Clients viewed the consequences of self-disclosure as equalizing the relationship, normalizing the client's concerns, and as facilitating insight. Another recent study (Simone, McCarthy, & Skay, 1998) found that counselors' primary reasons for using self-disclosure included promoting feelings of universality, encouraging the client and instilling hope, modeling coping strategies, fostering a therapeutic alliance, and increasing awareness of alternative views. Each of these counselor and client perceptions is consistent with the values and goals endorsed by feminist therapists.

A consequence of self-disclosure, especially of self-disclosure of personal experiences and attitudes, is that boundary management may be complex. Simone et al. (1998) found that the primary reasons why counselors choose not to disclose are to avoid the blurring of boundaries and to maintain a focus on the client. Because of the complexities of therapeutic boundaries, Wyche and Rice (1997) indicated that feminist therapists have not arrived at consensus regarding the use of self-disclosure, and urged therapists to engage in "constant self scrutiny" (p. 64) when considering self-disclosure. The Feminist Therapy Institute (FTI, 1990) code of ethics also indicates that self-disclosure should be used "with purpose and discretion in the interests of the client" (p. 39). Self-disclosure is inappropriate and potentially harmful when the counselor expects that the client should meet his or her needs for closeness and validation, holds assumptions that his or her personal experiences are indicative of the experiences of most women or men, or discloses inappropriately about current stresses or problems (Smith & Fitzpatrick, 1995). Knox et al.'s (1997) finding that helpful disclosure was associated with discussion about past personal issues may be especially pertinent. When counselors disclose about the past rather than the present, they are more likely to communicate about issues for which they have achieved significant closure, and are more likely to use self-disclosure in purposeful, thoughtful, organized, and client-affirming ways.

The use of touch in psychotherapy is also complex. The positive use of therapeutic touch can provide reassurance, acceptance, and comfort; reinforce or emphasize important verbal messages; decrease clients' anxiety and increase trust; convey the presence of a safety net within the psychotherapy relationship; and promote emotionally corrective experiences (Durana, 1998; Kertay & Reviere, 1993). On the other hand, touch may also be associated with sexualized behaviors and the invasion of boundaries. Furthermore, forms of touch that ordinarily seem rather benign may be experienced as frightening or intrusive by clients who have experienced victimization (Courtois, 1997; Phelps, Friedlander, & Enns, 1997).

A survey of clients' experiences of and attitudes about physical contact (Horton, Clance, Sterk-Elifson, & Emshoff, 1995) revealed that positive touch is associated with: (1) general clarity about boundaries in counseling and the meaning of touch; (2) the client's perception that she or he has control over initiating and sustaining contact; (3) the client's belief that touch is for his or her benefit rather than the therapist's; and (4) congruence between touch and the nature of the client's issues and the level of intimacy in the relationship. Positive evaluations of touch were also connected to the presence of a strong therapeutic alliance. Sixty-nine percent of respondents believed that touch supported greater openness and trust, and 47% indicated that touch was associated with enhanced self-esteem or self-acceptance.

Seventy-one percent of respondents who had been sexually abused reported that touch enhanced their sense of power, trust, and self-esteem (Horton et al., 1995). However, other qualitative data

reveal that some clients who have been abused are ambivalent about touch or see it as inappropriate (Phelps et al., 1997). Pope (1994) recommended that counselors use five considerations to guide their ethical decision making about the use of touch: (1) whether physical contact is wanted by the client, (2) the meanings of touch for the client, (3) the degree to which touch is consistent with treatment planning and goals, (4) the likelihood that the client may feel exploited by touch, and (5) the potential impact of the client's unique history, such as physical or sexual abuse, on the client's perceptions of touch.

Sexual misconduct is the most blatant of boundary violations in psychotherapy. Pope (1994) reported that there is "substantial evidence that therapists who become sexually involved with patients are overwhelmingly, although not exclusively, male, and that patients who become sexually involved with therapists are overwhelmingly, although not exclusively, female" (p. 15). Studies reveal that sexual involvement between a male therapist and a former or current female client accounted for between 86% and 92% of the cases reported (reviewed in Pope & Vasquez, 1998). Holroyd (1983) labeled male sexual intimacies with female clients as "the quintessence of sex-biased therapeutic practice" (p. 285) and noted that sexual misconduct is related to role-power and role-vulnerability (see also Pope, 1994). Gilbert and Scher (1999) proposed that the common thread underlying sexual intimacy with clients is male entitlement. This sense of entitlement takes on different forms such as the therapist's desires become the focus of counseling, the therapist rationalizes any potential harm to clients, or the therapist fosters and then exploits the client's dependence (Gilbert, 1992).

Female therapists are not immune from sexual misconduct or other problematic boundary violations. As noted by Brown (1991), adopting the title "feminist therapist" and assumptions about egalitarianism does not eliminate the possibility that one might engage in ethically problematic behaviors, including the sexual exploitation of clients. If a therapist assumes that adopting an ethic of egalitarianism erases power issues, the therapist may be especially vulnerable to violating clients' boundaries.

A national survey revealed that approximately half of the psychologists who responded had seen at least one client who had experienced sexual intimacies with a therapist (Pope & Vetter, 1991), and that most of these clients had experienced significant harm. A second survey revealed that one-quarter of respondents had provided psychotherapy to at least one client who had been sexually involved with a prior therapist (Parsons & Wincze, 1995). Providing information to clients about appropriate therapist behavior may contribute to prevention as well as help clients clarify options if they have been abused (Committee on Women in Psychology, 1989). Thorn, Shealy, and Briggs (1993) found that compared with controls, potential clients who read a brochure about sexual misconduct showed greater knowledge about inappropriate therapist behavior and indicated greater likelihood of responding assertively to therapist behaviors that made them uncomfortable. Prevention of therapist abuse may also be facilitated by training about dealing with sexual feelings, which are reported by approximately four out of five psychologists (Pope, Sonne, & Holroyd, 1993; Pope & Vetter, 1991).

Gender of Counselor and Client

The Division 17 Principles indicate that counselors should be sensitive to circumstances when it is more desirable for clients to be seen by male or female therapists. Fitzgerald and Nutt's (1986) commentary on the principles indicated that research on client preferences for therapist gender is "sparse and inconclusive" (p. 198), and Nelson's (1993) later review concurred with this conclusion.

Some studies indicate that women tend to show a greater preference for women therapists or a higher level of willingness to disclose and discuss highly personal and relational concerns with women counselors (e.g., Pikus & Heavey, 1996; Snell, Hampton, & McManus, 1992). However, Nelson's (1993) review concluded that although "trends" suggest that women clients may experience greater success with women counselors, "most findings have been inconclusive" (p. 200).

Findings about gender-pairings as they relate to counseling have been inconsistent, perhaps because of the many complicated aspects of identity and social roles that may influence and modify client preferences, including counselor and client class, gender role identity, ethnicity, sexual orientation, and age (Nelson, 1993; Pikus & Heavey, 1996). For example, two surveys have found that gay or lesbian clients viewed gay male and female and heterosexual female counselors as more helpful than heterosexual male counselors (V.R. Brooks, 1981; Liddle, 1996), suggesting that knowledge of counselor gender alone is inadequate for predicting optimal client-counselor pairings.

Given the conflicting findings associated with research on gender pairings, the recommendations of Fitzgerald and Nutt (1986) remain sound and merit repetition. Multiple personal and environmental factors and complex intersections of identity influence the therapeutic endeavor. Open discussion and negotiation with clients about their preferences is likely to serve the best interests of clients. When clients' presenting issues are related to issues of violence, such as rape, sexual abuse, domestic violence, and sexual harassment (Enns, 1993; Fitzgerald & Nutt, 1986), sensitivity to counselor-client pairings is especially appropriate.

Knowledge of Gender Issues in Assessment

Gender Bias in Diagnosis and Assessment

Chesler's (1972) book, *Women and Madness*, was one of the first accounts of how diagnostic categories pathologized women and supported their subordination. In light of this critique, early writings on feminist therapy expressed reservation about using diagnostic labels, arguing that they reflect the inappropriate application of social power, minimize the impact of environmental factors on symptoms, and reduce therapists' respect for clients. Furthermore, feminist therapists contended that the use of traditional diagnostic labels encourages therapists to focus primarily on removing intrapsychic conflicts rather than addressing the communicative function and social change implications of symptoms (Rawlings & Carter, 1977).

Building on these initial critiques, a variety of authors pointed out ways in which the symptoms displayed by men and women are consistent with gender role stereotypes and that women's efforts to conform more closely to gender stereotypes were more likely to be labeled as forms of pathology than were exaggerations of men's stereotypes (Franks & Rothblum, 1983; Kaplan, 1983). Feminist psychologists and therapists have continued to express concern about gender bias in assessment and diagnosis, including the tendency for therapists to minimize the impact of environmental factors on behavior, the presence of gender bias in psychometric instruments, the use of different labels for similar behaviors in men and women, and therapist misjudgments about appropriate diagnoses due to stereotyped beliefs about gender (DeBarona & Dutton, 1997; Worell & Remer, 1992).

Due to recent efforts to decrease bias in diagnosis and to pay closer attention to the role of culture in shaping symptoms (Walsh, 1997), the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 1994, *DSM-IV*) is generally seen as a substantial improvement over previous manuals (Kupers, 1997; Ross, Frances, & Widiger, 1997). However, Kupers argued that despite efforts to base diagnostic categories on empirical data and rigorous evaluation, the most recent version of the *DSM* has the potential to be used as a "more rigorous rationalization for pathologizing nonmainstream behaviors and attitudes" (p. 340).

Much of the controversy over bias in assessment and diagnosis during the last ten years has centered on the inclusion of three controversial categories that were included within the appendix of the revised version of the 3rd edition of the *Diagnostic and Statistical Manual Disorders* (*DSM III-R*; APA, 1987) and designated as diagnostic categories needing further study. These proposed diagnostic categories were named masochistic personality disorder (later renamed self-defeating personality disorder, SDPD); sadistic personality disorder; and late luteal phase dysphoric disorder

(currently labeled premenstrual dysphoric disorder) (Caplan, 1995; Ross et al., 1997). Feminist critics were successful in influencing authors of the *DSM-IV*, arguing that 85% of normally socialized women exhibit many criteria of SDPD and that the label does not acknowledge the survival value of passive or pacifying behaviors in reducing the emotional impact of physical violence that accompanies abusive relationships. Furthermore, the criteria for SDPD overlapped substantially with other personality disorders, lacked diagnostic power, and was supported by limited empirical data (Caplan, 1995). As a result, SDPD was removed from the diagnostic manual. Sadistic personality disorder was also eliminated because of lack of research support and potential for misuse (e.g., for avoiding the acceptance of responsibility for interpersonal violence).

In contrast to this outcome, premenstrual dysphoric disorder (PMDD) is included in the *DSM-IV* (APA, 1994) as a diagnosable disorder, and is currently listed in the main text under Depressive Disorder Not Otherwise Specified. A list of symptoms for further study remains in the appendix. This disorder received the approval of the psychiatric community despite inadequate empirical evidence, controversies about methodological weaknesses of studies on PMDD, and lack of consensus about symptoms of PMDD, its prevalence, and its validity as a distinctive disorder (Caplan, 1995; Figert, 1996). Tavris (1993b) concluded that "the psychiatric Establishment feeds the prejudice that women's hormones, but not men's, are a cause of mental illness" (p. B7). Kupers's (1993) argument that men also experience mood cycles that could be diagnosed as "pathological arrhythmicity" was not seriously considered by authors of the *DSM-IV*. Although the long-term impact of this controversy is not clear, a recent study of college women revealed that the very knowledge of PMDD as a diagnostic category increased women's perceptions that women's premenstrual changes are a general problem for women (Nash & Chrisler, 1997).

Studies continue to reveal that the gender and race of clients may influence assessments of their symptoms. For example, Landrine's (1989) study found that college students associated descriptions of personality disorders (e.g., dependent, antisocial) with gender, class, and racial stereotypes. More recently, Becker and Lamb (1994) presented clinicians with a male or female version of a vignette depicting a person who met criteria of both borderline personality disorder (BPD) and posttraumatic stress disorder (PTSD). The person in the female version was more likely than the person in the male version to be categorized as borderline. Furthermore, female clinicians were more likely to see PTSD as relevant to both versions of the vignette than were male clinicians, suggesting the male practitioners may "underestimate the negative effects of the sexual abuse on both male and female clients, raising the question of whether abuse survivors of both sexes might receive less than optimal treatment at the hands of many male therapists" (p. 59). Becker and Lamb also explored other labels that clinicians found relevant to the vignette and found that male versions were more likely to be rated as antisocial and female versions as histrionic.

A recent review of gender and diagnosis (Hartung & Widiger, 1998) noted that subtle forms of bias in assessment may be supported by sampling biases in research studies and subtle biases within diagnostic criteria. Many gender prevalence rates cited in the *DSM-IV* may be inaccurate due to the differential treatment seeking behaviors and referral patterns for men and women, resulting in biased clinical samples. In addition, the inclusion of only men or women as participants in research on specific problems (e.g., conduct disorder, eating disorders) may result in biased representations of men and women in many empirical studies. Furthermore, diagnostic criteria that are designed to be gender neutral "may disproportionately favor the manner in which the disorder appears in one gender relative to the other" (p. 267). Hartung and Widiger suggested that it is difficult to create gender neutral descriptions of problems when the manifestations of these problems are influenced by gender socialization (e.g. some personality disorders, conduct disorder, somatization disorder, sexual disorders). Some disorders that are described in gender neutral terms may actually be expressed differently in men and women, and subcultures of men and women. The failure to consider how gender may influence the expression of distress "is likely to result in the development of diagnostic criteria that are not equally valid for the two sexes" (p. 272).

In contrast to early studies that revealed clinicians' double standard of mental health for men and women (e.g., Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970), recent assessments suggest that practitioners' perceptions and evaluations are more neutral (Walsh, 1997). However, Becker and Lamb (1994) indicated that current forms of gender bias may "inhere in the current system of diagnostic classification itself, at times in association with sex of client, sex of clinician, and professional affiliation" (p. 59).

It is important for counseling psychologists to be aware of the subtle ways in which diagnostic categories may support inaccurate assessments of gender-related concerns. Some diagnoses, such as BPD, can be used to label persons who are experiencing gender-related problems (e.g., the consequences of sexual violence) in pejorative and intrapsychic terms (Brown, 1994; Chesler, 1997; Herman, 1992). The use of these categories may contribute to victim blaming attitudes, and decrease the practitioner's sensitivity to contextual factors that shape distress as well as the communication and coping function of symptoms. Commenting on the increased use of BPD in the recent past, Kroll (1988) suggested that BPD is becoming a "nondiscriminatory synonym for personality disorder" (p. 1025). Diagnostic categories that address contextual factors and power abuses that influence psychological distress (e.g., PTSD and complex PTSD, Herman, 1992) are likely to emphasize the adaptive role of symptoms and support positive treatment possibilities for both men and women.

In her 25-year reassessment of *Women and Madness*, Chesler (1997) proposed that clinical bias continues to be evident in a number of domains, significantly affecting the lives of women, and to a lesser extent, men. Counselors should be cautious about subtle ways in which assessment and diagnosis can lead to (1) the conceptualization of some medical illnesses as psychological or psychiatric problems; (2) the pathologizing of victims of sex discrimination and violence within clinical and legal systems; and (3) a lack of sensitivity to issues of diversity and concerns of people of color.

Assessing Gender-Related Concerns

Brown (1990) suggested that as a part of the assessment process, therapists should pay particular attention to (1) the meaning of gender in light of the client's family values, stage of life, culture of origin, and current social environments; (2) the degree to which the client complies with gender role injunctions, as well as the rewards and penalties the client has experienced for noncompliance or compliance; (3) the manner in which the client responds to the counselor's gender, as well as the therapist's reactions to the client; and (4) presenting issues that are often associated with gender. Assessment of gender-related issues also requires literacy regarding cultural, ethnic, and racial variations in prescribed gender roles, as well as subtle expressions of gender-related issues. Effective assessment of gender-related issues is facilitated by a cooperative and phenomenological approach in which the client's perspective is viewed as equally valid as the counselor's perceptions.

Central to assessment is the gathering of information about the client's strengths and coping capacities, which provide a foundation for developing new skills. In an effort to understand the ecological context and situational factors affecting the client, the counselor may also seek information about the client's support systems, level of social isolation or connection, and stressful experiences that may exacerbate gender-related issues (Brown, 1994).

In general, assessment is a shared and ongoing experience between the counselors and clients, and is integral to competent treatment. Whenever possible, clients should be encouraged to name the meaning of their experiences and problems. This is especially important when adult clients explore problems associated with sensitive issues, such as childhood abuse. If a counselor prematurely labels a client as an "abuse victim," the client may be less willing to disclose information, may experience the counselor as imposing an agenda, or may feel subtly disempowered. In contrast, when counselors ask questions that encourage clients to explore their experiences, feelings,

and behaviors in a comprehensive manner, clients become respected collaborators who may feel empowered by naming their own difficulties (Brown, 1994).

Theoretical Perspectives on Counseling

The introduction to this chapter highlights the importance of a social constructionist perspective that emphasizes the role of context in shaping gender behaviors and perceptions of men's and women's behavior. Despite almost thirty years of research from a social constructionist perspective, Bem (1993) contended that much of psychological theory and research: (1) is androcentric, as evidenced by the fact that psychologists continue to frame women's experience as it measures up to "normative" male experience (e.g., "women have lower self-esteem than men" versus "men are more conceited than women"); (2) tends to conceptualize men and women in polarized terms and "superimposes a male-female dichotomy on virtually every aspect of human experience" (p. 233) (e.g., through research that emphasizes gender differences rather than similarities); and (3) supports biological essentialism, or the notion that any differences that do exist are the consequence of "the intrinsic biological natures of women and men" (p. 233). Marecek (1997) elaborated on these themes, suggesting that psychology in the 1990s has been increasingly influenced by biological foundationalism. She argued that "both in psychology and in the culture at large, biologism goes hand in hand with political and social conservatism" (pp. 135–136).

Popular conceptualizations of gender, bearing titles such as *Men Are from Mars, Women Are from Venus* (Gray, 1992), expand on these themes and promote traditional gender behavior as normal, natural, and as highly adaptive. Gray's book, which is the best-selling hardcover tradebook of the 1990s (Gleick, 1997), is not based on empirical data, but disseminates theory without evidence, one of the major problems about which feminist psychologists have expressed concern since the 1960s (e.g., Weisstein, 1968/1993). The establishment of "Mars and Venus Counseling Centers" based on Gray's approach (Gleick, 1997) suggests that gender stereotypes may be supported and reinforced in at least some therapeutic environments.

These trends point to the importance of basing clinical work with men and women on sound theory and research that challenge stereotypes. Despite some conservative trends, acceptance and recognition of feminist therapy has increased and is receiving greater visibility. Two general texts on counseling theory currently include or will include a chapter on feminist therapy (Corey, in press; Sharf, 1996), and several videotape training series feature feminist therapy (e.g., Brown, 1996). The publication of a variety of recent books on gender and counseling (Gilbert & Scher, 1999; Philpot et al., 1997) and feminist therapy (e.g., Brown, 1994; Comas-Diaz & Greene, 1994; Enns, 1997; Worell & Remer, 1992) also point to the vitality of feminist and gender aware therapies. In the following sections, I address three theoretical perspectives (nonsexist, feminist, and gender-aware therapy) that are designed to support the development of healthy gender identities.

Nonsexist and Feminist Therapy

Nonsexist therapy is based on the premise that human development and behavior are determined more significantly by being human rather than being male or female, and that the goals of counseling and therapy are human goals rather than gender-related goals. Collier (1982) described nonsexist counseling as emphasizing "the need for *all* human beings to be able to actualize themselves regardless of biological gender" (p. 12). Thus, the goals of counseling include power over one's life, self-esteem, spontaneity and openness, the unstereotyped appreciation of others, independence, and individual growth (Collier, 1982; Rawlings & Carter, 1977). Rawlings and Carter proposed that nonsexist therapy may be especially appropriate for individuals with more traditional values for whom a more activist or feminist approach may be threatening.

Nonsexist and feminist therapists share the assumption that egalitarian relationships are central to growth and the goals of alleviating client distress and helping to achieve growth that is free

of stereotypes (Collier, 1982). Feminist therapists move one step beyond nonsexist therapy by endorsing the principle that the "personal is political" (Rawlings & Carter, 1977), which emphasizes the importance of increasing clients' awareness of the social and political contexts that influence their problems, and focuses on directly challenging gender role stereotypes and oppressive institutional/cultural structures. Another difference between feminist and nonsexist approaches is that feminist therapists are especially attentive to the manner in which so-called "nonsexist" goals, such as independence and assertiveness, may be incomplete because they are embedded in subtle androcentric aspects of psychological theory (Crawford, 1995; Gilligan, 1982). Feminist approaches also recognize that nonsexist behaviors such as independence and assertiveness may be differentially rewarded or punished, depending on the gender of the client who is enacting these behaviors and the gender stereotypes or egalitarian attitudes of those he or she encounters in the surrounding social environment.

A recent survey of 173 self-identified feminist therapists (Beardsley, Morrow, Castillo, & Weitzman, 1998) revealed that feminist therapy principles can be organized around five themes or factors: multicultural competency, multicultural awareness, awareness of multiple oppressions, the personal is political, and subversive practices. The subversive practices factor included items that referred to client-therapist collaboration about diagnosis, methods of increasing client access to services (e.g., through the use of a sliding-scale fees), and diagnostic practices for increasing client access to insurance coverage. In contrast to Beardsley et al.'s quantitative study of feminist therapists, Hill and Ballou (1998) gathered open-ended responses from 35 feminist therapists associated with the Feminist Therapy Institute. Their analysis revealed the following themes: attention to power differences, overlapping relationships, and therapist accountability; emphasis on the sociocultural causes of distress; the valuing of women's experience; the use of an integrated analysis of the multifaceted and interlocking aspects of oppression; and an emphasis on social change. The parallel findings from these two studies reveal that the original tenets of feminist therapy (the personal is political and the counseling relationship is egalitarian) remain important. As feminist therapy has matured, feminist therapists have also become increasingly attentive to multiple oppressions, diversity issues, and multicultural perspectives.

Initially proposed as a method for counseling women, feminist therapy is also of significant value for men. Ganley (1988) proposed that feminist therapy can be especially useful for helping men (1) learn to integrate relationship and achievement needs; (2) increase their capacity for intimacy, self-disclosure, and emotional expression; (3) create mutually rewarding, collaborative relationships; and (4) learn noncoercive problem-solving methods. Disagreement still exists about whether it is more appropriate for men to refer to themselves as "feminist therapists" or "profeminist therapists." However, a recent qualitative study of experienced feminist therapists revealed that 24 of 25 respondents believed that men can practice feminist therapy (Marecek & Kravetz, 1998a).

Ganley (1988) referred to the feminist activities of male therapists as profeminist therapy because this phrase affirms men's contributions to an egalitarian society while also acknowledging and preserving the uniqueness of women's therapeutic roles. Profeminist therapists encourage men to confront sexist behavior; redefine masculinity according to values other than power, prestige, and privilege; and actively support women's efforts to seek justice (Tolman et al., 1986). Profeminist treatment models may be especially useful for working with men who exhibit violent behaviors. A profeminist model for male batterers examines how men's controlling behaviors, such as battering, psychological abuse, and verbal intimidation, maintain power imbalances. Profeminist counselors actively interrupt men's efforts to devalue women and other less powerful individuals, confront their controlling behaviors, and help men and women work toward establishing egalitarian relationships. Anger management, communication skills training, stress management, and accountability training are also important (Harway & Evans, 1996; Tolman et al., 1986).

Gender-Aware Therapy

Good, Gilbert, and Scher (1990) indicated that feminist therapy has had a significant impact on the practice of psychotherapy. They noted, however, that many individuals have viewed feminist therapy as applicable to women alone. In light of social changes and research on the detrimental aspects of traditional male gender roles, they proposed gender aware therapy as a method for integrating the principles of feminist therapy with knowledge of gender. Therapists who practice gender-aware therapy: (1) view gender issues and roles as central components of mental health, (2) understand men's and women's problems in light of the social context (an extension of the principle that the personal is political), (3) challenge gender role injustices encountered by men and women, (4) work toward establishing collaborative therapeutic relationships, and (5) respect clients' ability to choose behaviors that clients perceive as right for themselves. G.R. Brooks (1990) elaborated on therapeutic goals for men that are consistent with gender-aware therapy. Therapists can help men (1) decrease emphasis on career and work-related aspects of identity, (2) develop interpersonal behaviors other than those that involve taking charge and asserting themselves, (3) facilitate emotional expression among men, and (4) explore new models of parenting and fathering.

Gender sensitive therapy (Philpot et al., 1997) is a variant of gender aware therapy designed for work with couples and consists of the phases of (1) reflection, which consists of the therapist's demonstration of empathy for both partners' positions; (2) psychoeducation about the social construction of gender; (3) confrontation of gender issues; and (4) brainstorming about solutions. Key components of this couples approach include the validation and normalization of gender role conflicts, the reframing of individual communication problems as products of conditioning, and the act of uniting against and defining the "gender ecosystem as the enemy" (Philpot et al., 1997, p. 179).

Gender aware therapy combines elements of both nonsexist and feminist therapy, but is distinctive in subtle ways. In contrast to nonsexist therapy, which seeks to provide equal treatment for men and women, gender aware therapy places emphasis on exploring gender issues and views this exploration as central to mental health. Gender aware therapy emphasizes the importance of altering gender injustices. Compared with feminist therapy, however, social action and the analysis of power dynamics and differentials appear to be less salient components of gender aware therapy.

Facilitative Therapeutic Procedures

Gender Role Analysis

Gender role analysis is a hallmark of feminist therapy, and involves exploring the impact of gender on psychological well-being or distress and using this information to make decisions about future gender role behaviors. Gender-related issues related to ethnicity, sexual orientation, class, and race may also be integrated within gender role analysis. The counselor and client explore how traditional gender behaviors are transmitted, how they serve a functional role within many contexts, how these behaviors are reinforced and maintained, and how they contribute to difficulties the client encounters (Philpot et al., 1997). The counselor and client also clarify ways in which traditional coping methods have become less successful over time and contribute to the person's distress as that person's attempts to meet life tasks that require a wider range of skills (Worell & Remer, 1992). Assessment of deviations from gender-role norms and the consequences of such noncompliance are also important. Questions about the client's current behaviors are also relevant, and may focus on how decisions are made (e.g., career and family relationships), how conflict is handled, how the client views and relates to his or her body, and how dependency needs are expressed. An exploration of any trauma history and related coping mechanisms is also relevant (Brown, 1986, 1990).

Gender role analysis, or gender inquiry (Philpot et al., 1997), is intended to help clients develop empathic rather than self-blaming attitudes toward themselves. Clients' gender-related problems are depathologized (e.g., "dependency") and understood within a social context (Brown, 1986, 1990). Techniques associated with a variety of theoretical orientations (e.g., cognitive behavior therapy, gestalt therapy) can be integrated with the goals of gender role analysis and used to challenge and change restrictive behavior patterns (Enns, 1997).

In recent years, substantial attention has been devoted to identifying the nature and consequences of gender role conflict and oppressive aspects of masculinity ideology for men. A variety of models have been proposed, including Pleck's (1995) gender role strain/conflict paradigm, O'Neil's (1981, 1990) model of gender role conflict, and Pollack's (1995) theory of men's developmental traumas. In general, these models propose that men's gender role socialization and the "masculine mystique" lead to the fear of femininity and a variety of negative consequences including (1) restrictive emotionality; (2) the overvaluing of control, power, and competition; (3) homophobia; (4) restricted ability to show affection and the sexualization of intimacy; (5) obsession with achievement and success; and (6) a variety of health care problems (O'Neil, 1981, 1990).

Many instruments are available for assessing masculine ideology and gender role conflict/stress, and can be used to facilitate gender role analysis with men (see Thompson & Pleck, 1995, for a review). Research studies have linked gender role conflict to a range of consequences (Good et al., 1995; Good, Wallace, & Borst, 1994), such as depression (Good & Mintz, 1990; Sharpe & Heppner, 1991), lower psychological well-being (Sharpe & Heppner, 1991), physical strain marked by physical illness or poor self-care (Stillson, O'Neil, & Owen, 1991), and the use of immature psychological defenses such as turning against others (Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998). The restrictive emotionality component of masculinity ideology appears to be a significant predictor of distress and gender role conflict (Fischer & Good, 1997; Good et al., 1994). As a result, counselors may need to pay special attention to male alexithymia, which involves a lack of words for emotion (Fischer & Good, 1997; Levant, 1995), and to facilitate men's expression of vulnerable emotions.

Gender, Power, and Power Analysis

Constructs such as gender role and gender role conflict focus primarily on differential socialization by gender, but do not include an analysis of power dynamics, institutional structures, and patriarchal family structures that reinforce gender role socialization and limit the capacity of individuals to initiate personal change. Power analysis is designed to help men and women make decisions about what forms of power they possess or desire to gain access to, and about how they can use or share power in ways that will optimize the likelihood that their efforts to change or influence others will be successful (Worell & Remer, 1992). Discussion of power and power abuses from the client's past may also reveal why clients feel devalued or powerless, freeing the person to "embrace unexpressed emotions and to confront dysfunctional power conflicts that inhibit growth" (O'Neil & Egan, 1993, p. 74). Although power analysis may lead to initial discouragement (one may become aware of the limited power of an individual), power analysis may also decrease a client's self-blame and internalization of external problems, and motivate the individual to influence creatively the institutional and interpersonal demands they face (Worell & Remer, 1992). By identifying potential sources of personal power, the client negotiates new ways of initiating change and influencing the environment (O'Neil & Egan, 1993). Power analysis and empowerment involve (1) the analysis of power structures in society; (2) discussion and awareness of how individuals are socialized to feel powerful or powerless; (3) clarification of how individuals can achieve power in personal, interpersonal, and institutional domains; and (4) use of advocacy to facilitate social change (Morrow & Hawxhurst, 1998).

Power analysis may be associated with different types of issues and outcomes for many women and men. Gilbert (1992) stated that "white men in our culture typically grow up with feelings of

confidence and specialness granted them simply because they are born male. This specialness is an essential aspect of male entitlement, which encourages men to feel that what they do or want takes precedence" (p. 391, see also Pyke & Coltrane, 1996; Steil, 1994). The differential levels of men's and women's sense of entitlement are often exhibited in heterosexual intimate relationships, and Major (1993) noted that men and women in heterosexual relationships often construct a variety of myths and cognitive justifications that reinforce socialized power differences. For example, the female partner may identify herself as having fewer needs than her partner, which supports her internal justification of role overloads. Men are likely to compare their household contributions with those of other men, rather than women and female partners. Other comparison standards, such as feasibility comparisons (the likelihood of being able to negotiate change) and self-comparisons (comparisons of one's current contributions with past contributions), may also decrease one's awareness of justice issues and support continuing inequities (Major, 1993; Pyke & Coltrane, 1996; Steil, 1994). According to a power analysis perspective, power issues such as these are sometimes invisible to clients, but should be addressed whenever possible.

The Gender Role Journey and Feminist/Womanist Identity

A variety of authors have noted that the clarification of one's gender-related identity can be understood as a developmental process. Downing and Roush's (1985) model of feminist identity development proposed that women who identify themselves as feminist negotiate a series of stages beginning with the passive acceptance of sexism, moving into a crisis stage of revelation, and proceeding to an embeddedness stage marked by intense connections to other women. The process culminates with synthesis, which involves the formation of an authentic feminist identity characterized by gender role transcendence and the integration of unique personal attributes with feminist principles; and active commitment, which entails commitment to social change.

Assessment of feminist identity can be facilitated with two instruments designed to measure this construct (Bargrad & Hyde, 1991; Rickard, 1987). Henderson-King and Stewart (1997) found predicted relationships between feminist identity phases and women's attitudes toward men and women's sensitivity toward sexism. The phase of revelation was most strongly related to sensitivity toward sexism and negative feelings toward men, and the strength of these relationships was smaller for each of the subsequent stages of feminist identity. The synthesis stage, which involves making assessments of others based on their individual qualities rather than group membership, was unrelated to attitudes about men. Fischer and Good (1994) also found relationships between women's perceptions of the presence of sex bias and both revelation and embeddedness phases. Another study (Gerstmann & Kramer, 1997) found a positive relationship between passive acceptance and absolute or dualistic thinking (16% of variance), and consistent but somewhat smaller relationships between synthesis of an authentic, personal feminist identity and dialectical thinking (making commitments based on an evolving and pluralistic framework). In general, findings suggest that feminist identification is complex, and manifested by a variety of attitudes. Questions still remain about the degree to which these "stages" are sequential or reflect qualitatively different experiences of feminism (Gerstmann & Kramer, 1997; Henderson-King & Stewart, 1997).

The relationship between feminist identity development and problems that women bring to counseling is less clear, as revealed by two studies on body image. Snyder and Hasbrouck (1996) found that body dissatisfaction and drive for thinness were positively associated with passive acceptance and negatively related to the final stage of active commitment. They also noted a modest negative relationship between the synthesis phase and bulimic symptoms and feelings of ineffectiveness. A second study (Cash, Ancis, & Strachan, 1997) found only a few small significant relationships between feminist identity and body image, but discovered that traditional gender attitudes about men's and women's social interactions were related to traditional and potentially dysfunctional personal appearance standards.

The gender role journey model proposes stages that parallel the phases of the feminist identity model, with the exception that it is described in more gender neutral terms (O'Neil & Carroll, 1988; O'Neil & Egan, 1992). During phase 1, individuals accept traditional gender roles and hold stereotypic views of masculinity, and during phase 2, persons experience ambivalence and confusion about gender roles and sexism. As awareness increases (phase 3), individuals direct anger and negative emotions at institutions and people who promote stereotypes of gender. During the final phases, persons engage in activist responses to restrictive roles and experience greater gender role freedom and integration. The gender role journey questionnaire (O'Neil, Egan, Owen, & Murry, 1993) can be incorporated into gender role discussions that occur during counseling, workshops, and other psychoeducational programs.

Helms (1990) has also proposed a womanist model of identity development that draws on some features of the feminist identity model and integrates them with other models, such as Black women's development. According to this model, healthy development may or may not be connected to feminism or activism. A study of college women revealed that early phases of womanist identity were associated with perceptions of gender bias in the college environment and lower self esteem; later phases were related to higher self-esteem (Ossana, Helms, & Leonard, 1992). Another study found that for White women, earlier stages of development were associated with greater psychological distress, but more internalized forms of womanist identity were associated with more positive mental health (Carter & Parks, 1996). For Black women, no relationships between mental health and womanist identity emerged. A third study found that for Black women, womanist identity was associated with racial identity development; for White women, racial and womanist identity development were not related (Parks, Carter, & Gushue, 1996). A final study of African American women (A.M. White, Strube, & Fisher, 1998), which used Downing and Roush's (1985) feminist identity model and Cross's (1991) racial identity model to assess identity, found that early stages of "acceptance" were related to greater acceptance of rape myths, and later stages were associated with the rejection of rape myths. These studies point to the value of integrating material relevant to feminism and womanism with models of racial identity. In general, early and more externalized definitions of feminism and womanism are more likely to be associated with psychological distress than internalized definitions. Furthermore, Black and White women may experience and negotiate these aspects of identity in different ways.

In addition to the intersections of feminist, gender, and ethnic identity, other aspects of identity, such as gay or bicultural identity formation, are also relevant to counseling. Reynolds and Pope's (1991) multidimensional identity model proposes that multiple identities may be negotiated in four ways, including identification with (1) one aspect of identity in a passive manner, (2) one aspect of identity through conscious identification, (3) multiple aspects of the self in a segmented fashion, and (4) combined aspects of the self through identity intersection. Each of these possible options represents an acceptable method for resolving identity issues, but each is likely to have unique implications for counseling.

Identity development models have important implications for the type of psychoeducational or counseling interventions that may be optimal at different stages of development. During early stages of "passive acceptance," clients may prefer relatively traditional counseling relationships, and therapists may focus on raising awareness by gently asking questions that help clients discover the impact of sexism, racism, and homophobia on their development. During "revelation" phases, when clients are becoming aware of oppression and its impact, counselors may need to provide additional support and encouragement as clients gradually move from seeing themselves as victims of discrimination to active coping agents. Several studies have noted that awareness of sexism and discrimination are associated with lower self-esteem or higher levels of psychological distress (e.g., Carter & Parks, 1996; Ossana et al., 1992). Clients who see the larger environment as sexist, homophobic, or racist may also be especially aware of hostility that is directed toward them as individuals, and this awareness may be exhibited as psychological distress.

Intervention tools that are most closely associated with feminist therapy, such as power analysis, emotion-related work, and self-disclosure, may be most beneficial during middle stages of development that are marked by awareness of bias and discrimination and the desire to interact with similar others in a safe, supportive environment. Group work may be most useful during these middle stages, when individuals solidify an emerging identity with those who share their values. For persons with more consolidated identities, individual decision making and critical thinking skills may be especially important as clients enact identities that may diverge at times from other persons' definitions of "liberated" behavior (McNamara & Rickard, 1989).

A Challenge: Men and Counseling

One of the major challenges to therapists is men's help-seeking patterns. Several investigations reveal that traditional masculine beliefs and gender role conflict are associated with lower levels of willingness to seek psychological help (e.g., Good & Wood, 1995; Robertson & Fitzgerald, 1992; Wisch, Mahalik, Hayes, & Nutt, 1995). Mahalik et al. (1998) found that men's gender role conflict is related to the use of defenses that protect men from acknowledging painful ideas and emotions, activities that are central to many forms of counseling. Men scoring high in gender role conflict showed less willingness to seek counseling when they viewed emotion-focused rather than cognitively focused counseling sessions (Wisch et al., 1995). However, Robertson and Fitzgerald (1992) noted that traditional men expressed openness to alternatives to traditional counseling and concluded that "simply changing the way in which some services are described (e.g., using terms such as *classes*, *workshops*, and *seminars*, rather than *personal counseling*) may encourage men with more highly masculine attitudes to take advantage of services that may be helpful to them" (p. 245).

Psychoeducation designed to educate men about the benefits of emotion and disclosure for enhancing mental health may be useful for overcoming help seeking reluctance. In addition, if counseling is portrayed as an activity that calls for the development of personal strength, competence, and courage through the discussion of personal concerns, men's resistance to seeking help may also decrease (Fischer & Good, 1997; Good & Wood, 1995). Many of the tools described in this section, such as gender role analysis, the gender role journey, and power analysis, are compatible with psychoeducational approaches that may help overcome men's resistance to help seeking. Given the fact that traditional men may be more open to cognitive and skill development approaches, emotion-focused work may be most effectively implemented by using bridging techniques that move the client from more comfortable cognitive engagement to less comfortable emotional expression and engagement (Wisch et al., 1995).

Social Change

Social change has been a central component of feminist therapy since its inception 30 years ago. Coster and Schwebel (1997) proposed that social activism has benefits for all psychologists and is an important component of self-care and well-functioning. Nevertheless, social change activities are relatively uncommon, even for feminist therapists. Beardsley et al.'s (1998) survey found that the following activities represent common practices of experienced, self-identified feminist therapists: using gender analysis and power analysis, maintaining awareness of diversity, and emphasizing collaborative therapy. In contrast, uncommon practices included the use of political analysis and encouraging clients to be involved in social change. Low endorsement of involvement in social change was also revealed by Marecek and Kravetz's (1998a) qualitative study, which found that self-identified feminist therapists "privileged private meanings, feelings, and ideas" (p. 26) and did not encourage clients to challenge systems of power. Both studies found that self-identified feminist therapists often feel isolated and fear public self-identification as a feminist therapist because of the powerful backlash against feminism during the 1990s. These findings suggest that it is

important for therapists to consider renewing their commitment to social change (Morrow & Hawxhurst, 1998).

Attitudes about gender have changed substantially during the past thirty years. Spence and Hahn's (1997) longitudinal study found a gradual liberalization of both men's and women's gender role attitudes. However, a gender gap still exists, with women endorsing more egalitarian values than men (Spence & Hahn, 1997). Twenge's (1997) meta-analysis also concluded that attitudinal changes also mark "women's increased endorsement of masculine-stereotyped traits and men's continued nonendorsement of feminine-stereotyped traits" (p. 305). The gender gap in attitudes about gender roles suggests that issues of power and equality have importance not only for counseling, but also for social change efforts.

FUTURE DIRECTIONS

In this final section, I briefly explore two important areas of theory and research that will be important to continued advances in our understanding of gender and counseling.

Theory and Research on Gender Role Conflict

Over the past 20 years, research on men's gender role conflict has established the presence and structure of gender role conflict and many of its psychometric properties (Good et al., 1995). Research also reveals that gender role conflict in men is complex, and at least modestly related to psychological distress. Good et al. found, for example, that 15% of the variance in men's psychological distress was predicted by gender role conflict. A series of studies have also found a rather strong relationship between gender role conflict or masculinity ideology and negative attitudes toward help seeking (e.g. Good, Dell, & Mintz, 1989; Good & Wood, 1995; Robertson & Fitzgerald, 1992; Wisch et al., 1995). Good and Wood found that 25% of the variance in men's help seeking behavior was explained by restriction-related aspects of gender role conflict. To date, limited research has examined male gender role conflict in gay men, clinical populations (Good et al., 1995), men of color (Doss & Hopkins, 1998; Stillson et al., 1991; Wade, 1996), and at different periods of the life span (Cournoyer & Mahalik, 1995). In the future, research on these topics as well as the impact of gender role conflict on the processes and outcomes of psychotherapy will be important (Cournoyer & Mahalik, 1995; Heppner, 1995). Further examination of gender role conflict as it relates to the types of presenting problems and the coping styles of different men will also be central to understanding the diversity and implications of gender role conflict in men (Heppner, 1995). Given the resistance of some men to traditional therapy, examination of the processes and outcomes associated with alternative forms of intervention (Andronico, 1996) will also be important.

During recent years, substantial theory and research have examined men's gender role conflict, and less attention has focused on women's gender role conflict. Future theory and research should further examine the similarities, differences, and interrelationships between men's and women's gender role conflicts (McCreary, Newcomb, & Sadava, 1998), as well as how gender role conflict is shaped by multiple aspects of identity, life circumstances, and important relationships. Exploration of the ways in which gender role conflict is moderated and shaped by specific relationships and by specific role demands and contexts will provide insight about the contexts in which gender role conflict is exacerbated and the contexts in which gender role conflict is less salient (Heppner, 1995).

One of the limitations of gender role conflict theory is that it focuses almost exclusively on individual manifestations of psychological distress and is infrequently integrated with knowledge of power dynamics, especially as they are manifested in abuse or violence (G.R. Brooks & Silverstein, 1995). A focus on gender roles alone provides limited insight about the social change

implications of men's and women's problems because the language of gender roles tends to focus on individualistic manifestations of gender and gender-related conflict rather than on institutional and cultural analyses of gender and power (Messner, 1998). Second, emphasis on separate masculine and feminine gender role ideologies can inadvertently support the exaggeration of differences between men's and women's role-related conflicts. Third, although discussions of gender roles and gender role conflict help explain how roles are reinforced and reproduced, they do not provide insights about large-scale social change. Messner argued that an emphasis on individual gender roles alone "implies a false symmetry between the male role and the female role, thus masking the oppressive relationship between women and men" (p. 258). These concerns point to the importance of integrating the increasing literature on gender role and gender role conflict within more complex models that attend to social-contextual factors and that suggest road maps for social change.

Theoretical and Research Perspectives on Nonsexist and Feminist Interventions

Feminist and nonsexist therapy approaches are supported by diverse theoretical traditions that are influenced by liberal, radical, socialist, cultural, women of color, lesbian, and postmodern feminisms (Enns, 1997; Walsh, 1997). The relationships between these theories and the practice of counseling need further examination. In the past, a variety of analogue studies have examined reactions of individuals to radical feminist, liberal feminist, and nonsexist approaches (Enns & Hackett, 1990, 1993; Hackett, Enns, & Zetzer, 1992; Hackett et al., 1996). In general, feminist respondents, including male participants with profeminist values (Enns & Hackett, 1993), have shown more positive reactions to counselors in general than individuals who do not endorse feminist values. Research participants have accurately labeled feminist approaches as feminist and have expressed positive attitudes toward feminist therapists. Respondents have also rated liberal and radical feminist counselors as emphasizing similar goals, but have viewed radical feminist therapists as communicating these goals more strongly than liberal feminist therapists (Enns, 1997). The findings of these analogue studies need to be examined through psychotherapy process studies with greater ecological validity.

Although feminist and nonsexist therapies have gained increasing visibility and acceptance in recent years, there have been virtually no efforts to study key features of these therapies within actual psychotherapy relationships. Exploration of the counseling processes and outcomes associated with specific techniques such as self-disclosure, gender role analysis, and power analysis is important. See Enns (1993) for additional commentary about process research on feminist therapy.

As noted in the section on assessment, bias in diagnosis remains an important counseling issue. In recent years, researchers have attempted to study the problems and symptoms of individuals from a strength rather than a deficit perspective. For example, Morrow and Smith's (1995) study of sexual abuse survivors' coping and survival skills contributes to a deepened understanding of survivors as strong and resilient individuals rather than as individuals with pathologies. Conceptual models built on studies such as this hold much more promise than do traditional diagnostic systems for supporting feminist and gender aware therapy.

Recent studies have focused on examining the attitudes, values, and theoretical diversity of actual feminist therapists (Beardsley et al., 1998; Hill & Ballou, 1998; Juntunen, Atkinson, Reyes, & Gutierrez, 1994; Marecek & Kravetz, 1998a, 1998b). These efforts have been facilitated by the creation of instruments that are designed to measure feminist identity development (Bargrad & Hyde, 1991; Rickard, 1987), agreement with different theories of feminism (e.g., Henley, Meng, O'Brien, McCarthy, & Sockloskie, 1998), and feminist therapy principles (e.g., Beardsley et al., 1998). Efforts to examine the diversity of masculinity ideologies are also emerging and will be important for supporting the study of masculinities (e.g., Fischer & Good, 1997). Given the diversity of feminist thought and masculinity ideologies, it will be increasingly important for researchers

and counselors to (1) clarify their theoretical assumptions, (2) examine the relationship between theoretical/political traditions and nonsexist/feminist practice, and (3) explore the degree to which the espoused theoretical perspectives of therapists are consistent with actual practice.

CONCLUDING THOUGHTS

Betz and Fitzgerald's (1993) review of current developments in counseling psychology concluded that the study of gender and its implications for counseling "may well be the fastest-growing area within counseling psychology today" (p. 346). This review has highlighted a small portion of the recent scholarship on gender as it relates to the Division 17 Principles. Perhaps the most significant change since the original publication of these principles 20 years ago is counseling psychologists' recognition of the diversity of gender effects and the highly complex manner in which gender intersects with other important aspects of identity. Weber (1998) suggested that central to understanding race, class, gender, and sexuality in an integrated framework is recognizing the common features of these constructs. All four constructs (gender, sexuality, race, and class) are socially constructed, embedded in complex systems of power relationships, manifest themselves at both social structural and social psychological levels, are expressed simultaneously, and have important implications for activism. In keeping with the characteristics of these commonalities, it is important for counselors to avoid simplistic generalizations about gender and to remain attentive to the diversity of gender effects within the complicated world of counseling.

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